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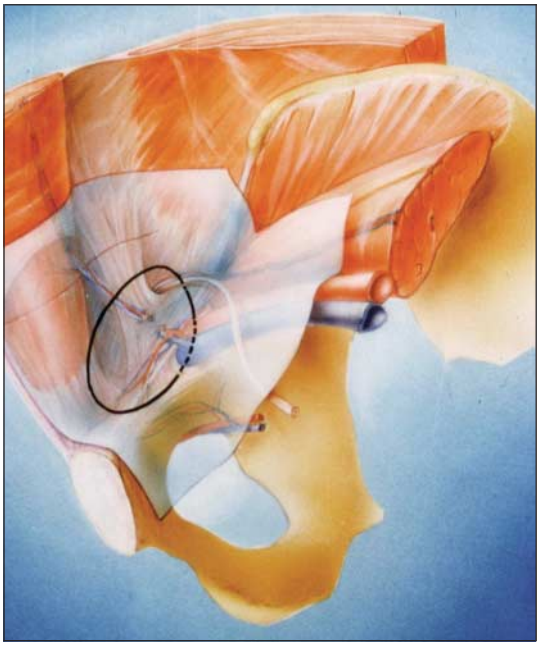
Treating inguinal hernias

Open mesh Lichtenstein operation is preferred over laparoscopy

Inguinal hernias are common; the lifetime risk for men is 27% and for women 3%.[1] It has been estimated that worldwide over 20 million repairs of inguinal hernia are carried out each year, the specific operation rates varying between countries from around 100-300 per 100 000 population per year.[2] In the United Kingdom some 100 000 inguinal hernias are repaired each year and in the United States 750 000. In the past decade the outcomes for surgery for inguinal hernia have been improved dramatically by the routine use of prosthetic mesh. Laparoscopic surgery has not affected surgery for inguinal hernia appreciably because of the increased costs and the reluctance of general surgeons to learn this complex procedure to correct a minor abnormality. Improvements in the delivery and quality of inguinal hernia surgery in the future will depend on the development of improved prosthetic mesh materials to reduce the incidence of chronic groin pain, which is now higher than recurrence rates. Furthermore, improvements in the organisation of care should include comprehensive education of patients, clinical nurse specialists, outpatient care for most patients, and greater use of local anaesthesia.

Repair of an asymptomatic bulge in an elderly, unfit man is not mandatory because the risk of strangulation is minimal. For symptomatic hernias in younger men a truss may allow continuation of heavy work with greater comfort while awaiting operation. A truss is an option only if the hernia can be reduced readily and completely and will remain in position despite physical activity or obesity. Patients can wait for surgery relatively safely because the cumulative probability of strangulation for an inguinal hernia is no more than about 2% per year.[3] For femoral hernias the risk is much higher—40% of patients are admitted as an emergency with strangulation or incarceration, and it is therefore important to differentiate between these two types of groin hernia. Femoral hernias should be treated urgently.

Five relevant factors should be considered in any evaluation of outcomes of modern day hernia surgery: technical difficulty for the surgeon; overall complication rates and the seriousness of possible complications; rehabilitation both short term and long term, including return to daily activities and work; recurrence rates; and socioeconomic factors, notably cost. Which of these takes precedence has been the subject of numerous clinical trials, meta-analyses, and systematic reviews. A systematic review by the European Union's Hernia Trialists Collaboration reported a threefold reduction in recurrence rates from 4.4% to 1.4% with the use of mesh compared with suture techniques.[4] The same group published a systematic review comparing laparoscopic with open methods of groin hernia repair and reported that in the hands of experts who practise the technique, laparoscopic repair was associated with less postoperative pain and more rapid return to normal activities. However, laparoscopic repair took longer to perform and was associated with an increased risk of rare but serious complications, such as bladder or bowel perforation and vascular injury.[5] In several European countries these conclusions are reflected in patterns of surgical practice with up to 95% of surgeons performing open mesh (Lichtenstein) repair and only 5% adopting the more complex, costlier laparoscopic operation, which has less margin for error.[6 7 8] This view was adopted by the United Kingdom's National Institute for Clinical Excellence, which recommended that open mesh repair should be the preferred surgical procedure for primary inguinal hernia.[9]



The preperitoneal space showing the placement of mesh to cover the myopectineal orifice, encompassing indirect inguinal, direct inguinal, and femoral hernia defects with a wide overlap of mesh to prevent recurrence

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After surgery for inguinal hernia patients should be encouraged to return rapidly to normal activities and work. "Take it easy" is the wrong advice.[10] After ambulatory surgery under local anaesthesia patients will usually be relatively pain free at three days, be able to resume normal activities at seven days, and be able to return to work at 10 days. With modern techniques and anaesthesia there is no justification for patients to remain off work for six weeks as previously recommended. Chronic groin pain has been increasingly recognised as a disability experienced by up to 5% of patients, causing notable effects on daily activities including walking, work, sleep, relationships with other people, mood, and general enjoyment of life.[11] Strategies to reduce the numbers of patients with chronic groin pain will include specific advice that modifies behavioural attitudes after surgery and technological improvements in mesh design.[12]

Stoppa has been the seminal thinker in developing not only the routine use of mesh for groin hernia surgery but also the concept of placing this into the preperitoneal space covering the myopectineal orifice through which all groin hernias protrude[13] (figure). These concepts have been fundamental in the development of preperitoneal techniques for repair of recurrent hernias and form the basis for laparoscopic hernia surgery.

The open mesh Lichtenstein operation has overcome the problems of technical difficulty and recurrence. Further improvements in inguinal hernia surgery will come about through increased use of outpatient facilities, attention to patient education, improving recovery patterns and new prosthetic materials to enhance long term patient comfort.[14]

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Health tourism

Where healthcare, ethics, and the state collide

No one should condone any fraudulent use of the NHS. However, following a consultation focused on the need to close perceived "loopholes that are open to abuse" by "health tourists," the government's announcement of its response also raised fundamental concerns regarding the balance between the potential responsibilities of doctors as employees and their ethical responsibilities to their patients.[1] Questions have also been asked regarding the actual extent of the problem of "health tourism." To date no serious quantitative study seems to have been made of this issue. The only figures available are anecdotal or based on extrapolation, and they vary considerably around the country. Further concerns relate to the applicability of suggested solutions and the public health implications of some of these.

Other than in the case of certain exemptions, specific regulations require NHS trusts to charge for health care that is provided to anyone who is "not ordinarily resident in the UK."[2] While this should be performed by overseas patient managers, pursuit of payment seems variably to have been achieved, with anecdotal reports suggesting various forms of abuse. Some examples cited in the government's consultation involve free hospital care for the dependants of people exempt from charges and for visiting business people or their dependants.

Analysis of the responses to the government's consultation shows that respondents differed markedly on how certain key issues should be addressed.[3] Though there is a risk of overgeneralising, these may be categorised according to their emphasis on costs or on the rights of the patient, thus providing another illustration of this dichotomy in a health service where both costs and rights are emphasised more than ever before.

This tension is exacerbated by the environment within which all healthcare professionals—whether clinicians or managers—work and are increasingly held accountable. Specifically, doctors are bound by the ethical code that underpins the patient-doctor relationship, which is based on trust, confidentiality, and the primacy of patient needs, and these are also required by their regulatory body.[4] In its response to the government's consultation the British Medical Association clearly highlighted, and the government accepted, these ethical concerns, which effectively indicated an absolute requirement for any decision regarding eligibility for care to occur outside the context of the clinical consultation.[5]

Ethical problems regarding eligibility for treatment are most profoundly shown by the issue of the

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